

Bureau of Health Care Quality and Compliance

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER  <b>NVS666HOS</b>	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____ B. WING _____	(X3) DATE SURVEY COMPLETED  <b>C</b> <b>06/18/2010</b>
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NAME OF PROVIDER OR SUPPLIER  <b>U M C OF SOUTHERN NEVADA</b>	STREET ADDRESS, CITY, STATE, ZIP CODE <b>1800 WEST CHARLESTON BLVD LAS VEGAS, NV 89102</b>
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(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
S 000	<p>Initial Comments</p> <p>This Statement of Deficiencies was generated as a result of complaint investigation conducted in your facility on 7/27/10 and finalized on 7/27/10, in accordance with Nevada Administrative Code, Chapter 449, Hospital.</p> <p>Complaint #NV00025973 was substantiated with deficiencies cited. (See Tag 154) Complaint #NV00025911 was unsubstantiated. Complaint #NV00025955 was unsubstantiated.</p> <p>A Plan of Correction (POC) must be submitted. The POC must relate to the care of all patients and prevent such occurrences in the future. The intended completion dates and the mechanism(s) established to assure ongoing compliance must be included.</p> <p>Monitoring visits may be imposed to ensure on-going compliance with regulatory requirements.</p> <p>The findings and conclusions of any investigation by the Health Division shall not be construed as prohibiting any criminal or civil investigations, actions or other claims for relief that may be available to any party under applicable federal, state or local laws.</p>	S 000 <i>pen</i> <i>9/2/10</i>		
S 154 SS=D	<p>NAC 449.332 Discharge Planning</p> <p>12. If, during the course of a patient's hospitalization, factors arise that may affect the needs of the patient relating to his continuing care or current discharge plan, the needs of the patient must be reassessed and the plan, if any, must be adjusted accordingly.</p> <p>This Regulation is not met as evidenced by: Based on interview, record review and document</p>	S 154		

If deficiencies are cited, an approved plan of correction must be returned within 10 days after receipt of this statement of deficiencies.

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE *[Signature]* TITLE *Coo* (X6) DATE *8/31/10*

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LAS VEGAS, NEVADA

Bureau of Health Care Quality and Compliance

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S 154	<p>Continued From page 1</p> <p>review, Patient #1 was discharged to home without documented evidence the patient had transportation.</p> <p>Findings include:</p> <ol style="list-style-type: none"> <li>1. The nursing documentation indicated the patient was instructed not to ambulate without assistance. The patient was placed in a wheelchair.</li> <li>2. The nursing documentation revealed the patient was upset because the facility did not have cab/bus vouchers and the patient did not have a ride home. The documentation indicated the charge RN would speak with the patient. There was no documented evidence this occurred.</li> <li>3. The patient was discharged with no change in the triage assessment pain level. Pain level documented as 5 out of 10.</li> <li>4. The patient had a documented diagnosis of Asthma and Sick Cell Trait. The patient walked home, which was almost six miles from the facility.</li> </ol> <p>Severity: 2                      Scope: 1</p>	<p>S 154</p> <p>S 154</p> <p><i>Approved 9/7/10</i></p>	<p><b>Tag S 154</b> <b>How the corrective action will be accomplished:</b> Discharge Transportation Assistance Program process was reviewed and determined appropriate to ensure safe patient transportation. This procedure will be presented again at the September 9, 2010 Emergency Department Staff meeting. The involved staff have been counseled by the ED Manager.</p> <p>The patient was given Percocet while in ED but at time of reassessment the Nurse did not communicate the continued pain to the Physician. This represents a policy variance. The involved Nurses were counseled regarding their patient care and required to re-review Administrative Policy I-87 "Pain &amp; Comfort Management".</p> <p><b>What measures will be put into place or systematic changes made to ensure the deficient practice will not recur:</b> A Performance Improvement measure regarding pain assessment and reassessment is performed monthly and shared quarterly with staff, Director and Manager.</p> <p><b>How the facility will monitor its corrective actions:</b> Policy compliance will be monitored through observation and questioning staff during Leadership Rounds.</p> <p><b>Responsible Party:</b> Director Emergency Department and Emergency Department Manager</p>	<p>Date Complete: 9-7-10</p>

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